**CMS 1500 Instructions**

The following sections must be completed correctly or the bill will be returned and payment may be delayed or rejected.

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| 1A* & 23* | CalVCP Application Number/Insured's ID Number |
| 2 | Claimant's Name |
| 3 | Claimant's Date of Birth |
| 5 | Claimant's address/Phone number |
| 11 | Insurance Policy information |
| 11A | Insured's Date of Birth |
| 11B | Employer's Name or School Name |
| 11C | Insurance Plan name or Program Name |
| 11D | Additional Health Plans |
| 17 | Treating Mental Health Provider and Licensure |
| 19 | Supervisory Mental Health Provider Licensure; if applicable |
| 21 & 24E | Diagnosis Codes from current Diagnostic Statistical Manual |
| 24A | Dates of services |
| 24B | Identify place of treatment – Office (O) or Home (H) |
| 24D | Procedure Codes – see common CPT Codes on VCGCB.ca.gov |
| 24E | Diagnosis Codes from current Diagnostic Statistical Manual |
| 24F | Charges – Your normal rate for the service provided |
| 24G | Units (please use hourly increments) for ½ hours please use .5 and 1 for 60 minutes (see Chart on website) |
| 24K | Intern's Registration Number; if applicable |
| 25 | Tax Id/SSN/FEIN Number of payee as registered with IRS |
| 28 | Total Charges/Billed Amount |
| 29 | Amount paid by claimant, or another reimbursement source |
| 30 | Balance due |
| 31 | Provider/Treating/Supervising Therapist's Name, License Number, Signature/Signature stamp and date |

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|---|---|
| 32 | Name & address where services rendered if different than box 33 |
| 33 | Provider/Payee's name as registered with IRS, address & phone number |